MAINE STATE LEGISLATURE

The following document is provided by the

LAW AND LEGISLATIVE DIGITAL LIBRARY

at the Maine State Law and Legislative Reference Library

http://legislature.maine.gov/lawlib

Reproduced from scanned originals with text recognition applied

(searchable text may contain some errors and/or omissions)

STATE LAW LIBRARY
AUGUSTA, MAINE

HEALTH CARE COST
PUBLIC HEARINGS - PROCEEDINGS

SPONSORED BY THE MAINE COMMITTEE
ON AGING, AD HOC COMMITTEE
ON HEALTH CARE COSTS

April 13, 1982 - Saco
April 14, 1982 - Augusta
April 20, 1982 - Bangor

KF
3825
.Z99
M246
1982

April, 1982

MAY 23 1988

AUGUSTA, MAINE

HEALTH CARE COST PUBLIC HEARINGS

The following represents a summary of the presentations made by the panel members at each of three Health Care Cost Public Hearings which were held in April, 1982 by the Maine Committee on Aging. In some instances, the text represents a synopsis of the panelist remarks, while in some instances the text represents a recorded statement.

A summary of the consumer's comments made at each hearing is also included in this package.

OPENING STATEMENT

April 13, 14 And 20
Public Hearings

Alice Bourque, Chair, Ad Hoc Committee on Health Care Costs
(From notes)

Good morning. My name is Alice Bourque. I welcome you to the first of three hearings on the High Cost of Health Care being held this month in the State by the Maine Committee on Aging.

We are all aware of the fact that the high cost of health care has become a national concern. We are here today to find answers to your questions about hospital and medical costs.

I am a member of the Maine Committee on Aging, a fifteen member board that serves as an advisory committe to the Governor.

At the September meeting of the Committee I casually asked if others shared my concerns with the high cost of health care. Every member expressed concern and since this problem affects the elderly in Maine, an Ad Hoc Committee was formed to study the issue and I was asked to serve as Chair.

Our first meeting was held in October. Since then we have met with representatives of the Maine Medical Association; the Maine Hospital Association; Blue Cross/Blue Shield; the Health Facilities Cost Review Board; the State of Maine Bureau of Insurance; and Senator Mary Najarian, who is a pioneer in the investigation of the high cost of health care in Maine.

In February, we held a press conference. Your responses convinced us that we needed these hearings to talk with consumers. Your letters were about actual cases that needed to be heard.

I have here 4 items that sparked my concern with the high cost of health care. First, I have a woman's hospital bill which totaled $46,000. This was for an operation where the man eventually passed on, and the spouse was left with paying the balance after Medicare and private health insurance paid. The balance totaled over $10,000. The spouse had never asked for an itemized bill - even with such a large charge as this.

Second, I received a bill which allowed a category of "other" charges which I wanted to find out more about as to what I was being charged for. I went to the hospital and was eventually told that it was presented on the bill that way because that was how it was entered into the computer. When asked if they could change it, I was told that they didn't know.

Third, I had a balance due me from Medicare for a doctor's charge. It was incorrect, so I went back to the doctor's office and asked them to correct it - adjust it downward - to reflect what was actually owed me. Instead, I got a check in the mail which was more than my original check. Now most people I tell this to say "cash it." I won't. But I wonder how often this type of thing occurs.

Finally, we have a number of examples of duplicate billings which are taking place whereby Medicare and other payors are both paying the bills.

My concerns are as follows:

1) The doctor, whose sole concern is and should be, healing and care of the sick <u>is the only link</u> between his patient and <u>all</u> the health care services. His role is to make his patient well.

2) The consumer of health care services, the patient, who walks through the doctor's door behaves like a character in a fairy tale who thinks that a fairy godmother is paying the bills.

3) I believe because there is a link between the patient and the physician, the consumer often unjustly views the doctor as a conspirator in the game of health care. The doctor is no longer seen as a source to be relied upon.

4) The third party payor system is an incentive for hospitals to spend more money. Hospitals have become big business in providing health care for profit.

5) The consumer is considered to be of little importance and does not need to see an itemized bill.

6) The consumer encourages this conclusion without realizing that he is the start of the entire production. Since without the patient there is no need for the other players in the cast! However, in reality, the patient needs the medical services and the providers of the medical services need the patient in order to survive.

We hope that this hearing will lead to a higher degree of mutual respect between the consumer and providers of health care services.

April 13, 1982 - Saco

Panel Members' Presentations

Ted Hussey, Senior Vice President (Synopsis of remarks)
Maine Hospital Association, Augusta

I don't come with answers. I come to listen. I want to work with you to seek a solution. There are 43 not-for-profit hospitals in Maine. We have increasing concerns in the Maine Hospital Association because many hospitals are closing. Hospitals in this state are small compared to nation. People in Maine are dependent on these and are entitled to same quality of health care as rest of nation. With small hospitals its harder to obtain that level of quality.

The nation is aging. In today's hospitals there is an increasing amount of care for the elderly. Care for elderly is more expensive. Hospitals have to deal with a complex Medicare/ Medicaid billing system. I heard the Chair call for itemized bills. But because we work on complicated billing and auditing procedures which we want to but can't change, this would be difficult. We are ready for change. We know people want the least expensive care but we want to assure quality care - as good as rest of nation.

We don't have the answers. We want to work with you. We have no easy solutions. Thank you.

Dr. Leopold Viger, Biddeford (Synopsis of remarks)
Representing Maine Medical Association

My views are my own. I don't represent the MMA today.

We have some bad doctors and some good doctors. Ninety-nine percent are good. Some are mistaken in the way they practice because of the way they were brought up. Third party delivers 85% of hospital changes - probably same with doctors. So we have a lot of physicians who can't understand the pre-Medicare system.

Forty percent of my early hospital work was written off. Today all of the services are reimbursed. It used to be said that Maine doctors weren't well trained. Thing was, they were family practitioners. But now everyone is a specialist. Cost has gone up. Also training does not give any credance to judgement/common sense. It is all technology. Clinical judgement is at the end of the list in importance.

A lot of the changes in my office are lab changes. Void because there is a 3rd payor in all of those cases.

When Medicare was being formulated, I suggested that we get together with consumer to deal with this new program. But no one seemed to want to do that.

Harry Truman said "The public deserves it," Well, the public is getting it.

Thank you.

John Reake, Financial Specialist, Medicare/Medicaid
Health Care Financing Administration (Synopsis of remarks)

My involvement with Medicaid is limited.

Nationwide cut in Medicare contractors of $30 million. With inflation and all, we had to deal with cuts. When its becoming more important to monitor Medicare dollars, we have less money to do so.

The remark that no one is minding the store bothered me - we hope that we are. To the extent that contractors can control such overpayments, we try to. The Professional Standards Review Organization was eliminated - the Medicare contractor has to pick up that responsibility as well.

Tom Record
Maine Bureau of Insurance (Taped)

As most of your know, I have spoken with some of you people before. At this point and time the Bureau is involved in developing regulations to deal with Medicare Supplement Insurance. I know we've been at the drawing board for some time now and hope to be able to tell you people today when the public hearing was going to be but unfortunately I am unable to do so but do believe it will be very soon. We also, pursuant to the Blaine House Conference on Aging recommendation, put out a survey of insurance carriers in the state as to who provides the coverage for intermediate care facilities. We received the responses from most of the insurance companies. I think probably we all know who provides that coverage. We're in the process of compiling that information and will get that out soon.

Panel Members' Presentation

David Cluchey, Chairman
Maine Health Facilities Cost Review Board (Taped)

For those of you who do not know what the Maine Health Facilities Cost Review Board is, it is an independent citizens dominated Board that is established by statute. I suppose its primary responsibility is overseeing the coluntary cost and containment effort for health facilities in the State of Maine. The statements were made that health care costs have increased inadequately in recent years. I think perhaps I could illustrate that with a few figures specific to Maine.

Between 1955 and 1979, our health facilities' cost in the State increased an average rate of 13%. During those same years inflation was increasing at a rate of 4.3% on an annual basis. The hospital industry in the State of Maine is now a 400 million dollar industry. Approximately, half of that, 200 million dollars, comes from tax money through the Medicare and Medicaid Program. The trend has not abated, it is continuing. The most recent figures for February show an inflation rate of under 4% and these are national figures while health facilities costs increased in excess of 11%. Our Board as I indicated at the beginning is charged primarily with overseeing the current voluntary cost containment effort. In May of last year the Governor asked to attempt to evaluate that current voluntary effort and to reach a conclusion as to whether the effort was exceptional or whether some change was needed in the current system. We spent seven months on that study and we issued a report that I assume some of you are familiar with on hospital cost containment in Maine. We concluded on the basis of our seven month study that the current voluntary system shows no evidence of being effective in containing the cost of health facilities. We base that on analysis of only one year data because that is all that was available. That data indicated that the Health Facilities in Maine for the data that was available had budgeted increases in their budget of approximately 35 million dollars and had in fact collected some 44 million dollars over the previous year's budget.

When we concluded our study and sat down to develop our recommendation it became clear to us that one of the major problems with increases in health care cost was the current payment system. Mr. Hussey mentioned problems with the current reimbursement system.

David Cluchey, Chairman (Cont.)

Approximately, 75% of hospital costs are now reimbursed on a cost basis - that is, the hospital incurred the cost and Medicare and Medicaid reimburse those costs. That seems to us to be a system which provided no incentive for containing costs. If someone is going to reimburse you your cost, you have an incentive to keep those costs down, to keep them lower and find new ways to provide services to lower costs. So we have recognized in our report that the State undertakes to support a prospective payment system; a system under which hospitals would know in advance how much money they were going to have to spend within certain parameters and with flexibility for exceptional circumstances but that they would know basically in advance how much money they would have to spend for a given year and would be required to live within that amount.

A proposal is currently before the Governor and we anticipate that the Governor will be taking some action on it fairly soon. This is a continuing problem and there are other approaches to the problem than the one we suggested. That is, the financing system is not the sole cost of increases in health care. There have been tremendous advances in medical technology. I think it is fair to say that the quality of care has increased dramatically over the years. There are other issues relating to cost such as health maintenance and medicines that are important. Other issues such as movement from inpatient services to out patient services, which has been shown to be a less expensive provision of services - it has been shown to be substantially less expensive than inpatient hospital services. We believe that all of these expenses could be explored but quite frankly we have a substantial set of recommendations which we made to the Governor.

James Harrod, Vice President of Public Affairs
Blue Cross/Blue Shield

Thank you. I'm not sure if there is anything left to be said except I thank you for calling first party payor a fairy godmother. Nicest thing anyone has ever said about it. Given the fact that we're the fairy godmother, I think in looking at the system we ought to try to stay away from the good guy, bad guy aspect as much as possible. I think for the most part from what I've heard and what I've seen, basically, there are a bunch of good guys out there trying to make a system that provides a very sound quality health services but provides it in a little more cost effective way. An awfully lot of issues we've been pulling up today we have been dealing with for years in the health system, the whole issue of cost of care and quality of care. There is also an issue of medical ethics. I don't think its a favorite issue but that presently gets into the cost/quality issues and again from the mechanics of how services are paid for and the idea of prospective reimbursement was brought up a couple times. We agree that that is a method of reimbursement which is worth looking at. It certainly is sound in principle but as Mr. Cluchey pointed out that is not the only cost when you are taking a look at health costs. Maybe the word "problem" isn't necessarily right either. I recently had a close encounter with the health system and the way services are provided now is a good deal different from the way they were provided 10 years ago. The ability of the practitioner and the amount of technology available to recover from a very serious procedure will continue to increasingly unfold over the years. So there are an awfully lot of parts of the equation that need to be dealth with.

Certainly, we have seen the amount we have paid out in benefits increase on our Blue Cross. This past year, we paid about a hundred and ten million dollars worth of services to Maine people. About fourteen million of that for a companion plan which many of you know is for supplemental coverage that Medicare will provide. Part A of Medicare as you know pays for a hospital or hospital type services. We paid out over a hundred and fifty million dollars for people on Medicare and Medicare recipients last year. A fantastic amount of money and to be able to deal with that amount of money, a bureaucracy has to be established. And obviously there are ways to make that bureaucracy that claims the administration process work better. And I too will look forward to hearing both your problems and your ideas.

April 14, 1982 - Augusta

Panel Members' Presentation

Ted Hussey, Senior Vice-President
Maine Hospital Association

(Same General Comments)

Dr. Brinton Darlinton
Representing Maine Medical Assocation (No tape available)

Joseph Finnegan,
Health Care Financing Administration (Synopsis of remarks)

Congressional expansion of Medicare Services were discussed. Some of the Administrations FY '83 changes in Medicare were reviewed.

Tom Record
Maine Bureau of Insurance

(Same General Comments)

Bob Clarke, Executive Director
Maine Health Facilities Cost Review (Taped remarks)

The Health Facilities Cost Review Board was created by the Legislature. It is an independent state agency composed of 10 members, 5 public members and 5 who represent 5 groups - the Hospital Association, the nursing home industry, the private insurance industry, the Department of Human Services and the Bureau of Insurance. The Governor appoints all of the members. It is a part-time Board, not a bureaucracy.

About a year ago the Governor asked us to carry out a study to accomplish three tasks. First, examine the current financing of hospitals; second, assess the on-going voluntary effort at restraining the increases in hospital costs; and third, was to look to any alternatives to that voluntary system and to specifically examine mandatory rate-setting and the possibility for implementation here in Maine.

The Board conducted the study and presented the finding to Governor Brennan. In summary we found that there has been tremendous progress in the quality of medical care in 25 years. And it has come at an enormous price. What were the causes of the great increase? Inflation was one-third. Increases in the number of people and the number of resources (drugs, supplies, technology) represented a large portion of the increase. And finally, an increase in the level, volume of services provided caused an increase.

The system for financing hospitals on the retrospective cost reimbursement system does not contribute to the efficient production of services in hospitals. The level of insurance coverage has risen a great deal - which reduces the economic accountability of you and I because we are not paying out of pocket and therefore, controlling it.

We found the voluntary system has very weak incentives to encourage compliance. Hospitals are paid on the basis of what they spend, so there is no incentive to reduce costs.

We looked at other kinds of programs, the mandatory ones and found they provide stronger incentives. They pay according to a prospective reimbursement system - they pay for services on the basis of pre-established rates. So if the hospital was efficient, it could keep the savings.

The Board recommended that the State adopt a prospective system for hospital services which should be administered by a state and non-state agency. That would provide for incentives for efficient behavior and penalties for inefficient behavior. The second thing we recommended was better coordination of the various agencies which deal with hospitals. Finally, we felt that health maintenance programs and other such consumer programs must be further developed to have the consumer more involved.

Jim Harrod
BC/BS

(Same General Comments)

April 20, 1982 - Bangor

Ted Hussey
Maine Hospital Association

(Same General Comments)

Dr. George Bostwick, President
Maine Medical Association (Synopsis of comments)

As the Presient of the Maine Medical Association, I represent 1200 - 1300 physicians throughout Maine. And I would suggest that we see ourselves as the patient's advocate in the health care system, and am anxious to work with you on these problems.

Panel Members' Presentation

Gordon Browne, Director, Bureau of Health Planning and Development, Department of Human Services, Representing the Health Facilities Cost Review Board (Synopsis of Comments)

Explained that he sat on both the Health Facilities Cost Review Board and the Voluntary Budget Review Organization. Explained the function of both. Discussed the recommendation of the Board.

Tom Record
Bureau of Insurance

(Same General Comments)

Jim Harrod
Blue Cross/Blue Shield

(Same General Comments)

Synopsis of Issues Raised by

Consumers at Public Hearings

1. Howard Browning, Biddeford - Member of the Board of York County Health Services.
   - Was concerned that York County Health Services had not been invited to serve on the panel.

2. Shirley Ouprie, Director, York County Health Services -
   - Was concerned that the film "Medisense" blamed the consumers in the system, and she felt that the real culprit is the medicare payor and the regulations.
   - Also expressed concerns about the new medicare rule which limited home health a great deal and is causing premature nursing home placement.

3. Bev Turrel -
   - Offered assistance in examining the cost of community health.
   - Expressed concern about the restrictive nature of medicaid/medicare regulations.
   - Suggested that consumers talk more to their state legislators and their congressmen about the health care cost problems.

4. Stuart Fergusson, No. Whitefield -
   - Asked Dr. Viger if the players were the patient and the physician. Dr. Viger responded that the third party payment mechanisms pay for expensive hospitalization but don't pay for routine exams and other preventive approaches to health care. Dr. Viger expressed frustration in that that was the system and it would not change. He said "It is chaos and it won't change until people recognize that the system must change." He said that the change won't come from doctors -- the consumer must force the change.

5. Louise White
   - Asked Dr. Viger how consumers could make the doctor interested in what the services they order cost.

   Dr. Viger responded by saying that it will be difficult because doctors have a vested interest. Stressed again that it is up to the consumer to force a change in the way the system works.

6. Lester Nichols
   - Asked how medicare establishes the maximum allowable fees for physicians' services.

   John Reake explained the assignment issue and the way medicare establishes maximum fees.

7.
   - Asked to have the development of the fee schedules explained again. Mr. Reake did so.

8. Howard Browning
-Stated that BC/BS has cut every single doctors bill he has ever had. Therefore, he questioned the "reasonable cost" determination in that it was always too low.

9. Eleonora Fuvre, Ocean Pines
-She wanted to get itemized bills because the bills she got now from the hospital did not provide enough information. She suggested the hospitals provide itemized bills automatically.
Mr. Reake told her that the American Society of Internal Medicine had been advocating for a "super bill" which would show the patient all the procedures and what they cost, but Medicare had found it unacceptable. He said Medicare had their own system and they won't change it.

10. Stuart Fergusson
-Asked why some insurance companies examine itemized bills before they will pay anything, while others don't use them at all.
Ted Hussey responded that the Medicare payment system does not allow for the use of itemized bills because the payment is made at an end-of-the-year audit. "The hospital has been forced to respond to the payor - Medicare. As the consumer shows more concern, the system will change. But it must be done by the consumer," said Hussey.

11. Louise White
-Asked why central supply costs can't be controlled, such as the unnecessary use of patient care kits.
Ted Hussey responded that the use of precharged care kits are used for efficiency.
Dave Cluchey commented that because the hospital can pass the costs onto a third party payor, they have no incentive to provide a cost efficient system.

12. Consumer
-Expressed concern about the insurance policies that are advertised on TV, and the elderly's propensity to purchase them because they don't know what Medicare and BC/BS covers and they are scared.
Tom Record said that over insurance is a problem. Suggested that people use the buyers guide to determine what kind of coverage they need.
-Wanted to know how to find out what Medicare will pay for.

13. Stuart Fergusson
-Felt that the sign-off on the admission form provides a blank check to the hospital.

14. Cluchey
-Stressed the importance of discussing issues with Congressional Delegation and state legislators.

15. Consumer

-Suggested that itemized bills be provided by hospitals.

Ted Hussey said that the requirement of an itemized bill would raise costs to the consumer.

16. Steve Taylor, Palermo - 71 years old

-He felt that the patient has no control over what the hospital charges, and whatever the doctor ordered, you paid for.

-Wondered what the salaries of the directors of hospitals, and the physicians are - felt that they were relatively high.

-Asked why there are so many doctors assigned to each case. Felt that this caused the charges to go up, because each of the doctors bills for their services. He suggested that doctors do this because they know Medicare and BC is paying.

-Concerned with doctors who never see the patient and still bill for their services.

-Said that hospitals charge for itemized bills.

-Asked why so many doctors are coming up to Maine to practice.

-Asked why it cost 10% a year more for every year after age 65 before you sign up for Medicare - he felt that he wasn't sufficiently informed and felt that it was a scheme to get more for Medicare B because he didn't sign up when he was 65, and he felt it was unfair and if he had known this, he would not have waited.

-Expressed concern that the Bureau of Insurance had let his BC coverage go down and his premiums go up 50% while inflation only went up 14%. (It was explained that the coverage he had was the Federal Employee Blue Cross/Blue Shield which is not controlled by the State of Maine.)

-Had several complaints about the Federal Employees Health Benefits Program - through BC/BS. He found that many services were not covered by his policy.

-He felt that the consumer has no control over what services are ordered and what they cost, and then they are faced with paying for what Medicare won't pay for.

-Wanted to know what the best insurance policy he should have to compliment Medicare. Complained that the Bureau of Insurance did not help consumers and suggested that the Bureau of Insurance should rate insurance companies as to which policies are the best to supplement Medicare. The consumers don't know what to buy and really need some assistance.

Tom Record said that all the Bureau could do was to say whether policies were in compliance with the medigap regulations.

17. Ivey Norten, Pittston

-Complaint that it took her 16 phone calls to get an itemized bill from Augusta General Hospital. I had to have the itemized bill to send into my insurance company.

-Wanted to complain to someone that she had been given medication that she was allergic to.

Hussey suggested she go to the administrator of the hospital.

-Requested that itemized bills be provided to consumers. Said that when she eventually got the itemized bill she found she had 3 medicines on her bill that she was not given.

-Asked why Augusta hospital is such a bad hospital.
-Had called BC/BS and Medicare about a claim and no one could answer her questions.

18. Joe Dressler, Central Maine Power Company
-Wanted to know how a major employer can comment on the recommendations of the Health Facilities Cost Review Board.
-Expressed interest in the recommendations of the Board.

19. Man Consumer
-Complaint that unnecessary tests were done on his wife - once before going to the hospital and again on admission to the hospital. The tests were done 3 times and BC/BS paid for all 3. That's why BC/BS costs are so high.
-Complaint that he was charged $325 for medications in only a 4 day hospital stay.
-Hospitals charge for itemized bills which they shouldn't do.
-He was sent a bill for medications that were given when he wasn't even in the hospital. The hospital took a long time to change the charge, and he refused to pay until the charges were taken off.
-Suggested that stopping doctors from conducting unnecessary tests would cut down on health costs.

20. Steven Taylor
-You get 4-5 doctors in on one case and they all order something else. My wife had 5 x-rays and a lung scan during a hospital stay. Medicare paid for all of them. Suggested that the x-ray people should alert someone to excessive x-rays.
Ted Hussey said that he recognized that the payment structure needs alot of work. He said that the only way to change the system will "stem from this room - consumers have got to demand itemized bills."

21. Elizabeth Whitehouse
-She gets husband's Social Security and having a hard time living on it. The Part B deductible for Medicare has gone up and she has not been able to pay the deductible, so she has been going without necessary health care because she can't pay the deductible.
-The health care system was described as a "nightmare." Nightmare is the word she used "for the public that has to pay" for the health care they get. Her hospital bills would not be paid by her Medicare and BC/BS. She was forced to receive Medicaid to pay her bills. She really did not want to be on Medicaid. She just needed a loan because she had no resources.
-The federal government must start examining the costs more closely and that there are excessive charges - are these costs really necessary, they are much too high.
-Physicians who didn't accept assignment cause a hardship for low income elderly.
-Concerned about the excessive cost for supplies that are charged from the hospital - thermometers, sanitary supplies, elbow protection pads, tissues, disinfectant, etc. Suggested that patients be allowed to bring medications and supplies with them from home rather than getting charged by the hospital.

-Concerned about the duplicate charges the hospitals charge Medicare for.
-Medicare must check with patient - are these costs really what happened to you?
-Medicare only seems interested in making sure that all charges are consistent for everyone, not about excessive charges or duplicate payments.
-Situation where Medicare was charged twice for same thing by hospital. Took 4 months for Medicare to respond.

Ted Hussey said that the references to hospital supply costs, bringing things into the hospital to use would be hard. Also, itemized bills present problems for hospitals. Hospitals don't get paid by Medicare/Medicaid on the basis of bills. Hospitals get paid on a complicated cost analysis basis which is done at the end of the year. Really, the end of the year determines what the hospital is paid - not for each person, but for all the people who use the hospital receiving Medicare. We would like to see that system changed. But it would be extremely difficult and costly for hospitals to set up an entirely different system of itemized bills, because they are set up on the Medicare payment system. He said that the need for itemized bills had been frequently expressed, so there was a need to sit down and decide what can be done.

22. Stuart Fergusson
-Expressed concern that the Ad Hoc Committee had heard complaints of duplicate payments/billings an awful lot - statistically more frequently than what we expected.
-Cited a case where an operation was not performed, yet Medicare got billed for the operation.

23. Elizabeth Whitehouse
Suggested that people stop thinking that Medicare is a free gift, and that people be better educated about what Medicare covers.

24. Consumer
-Concerned that people think that Medicare pays for everything, when it doesn't. In fact, you never know what Medicare will pay for because it changes all the time.
-Had problem getting itemized bill.
-Told of an instance of different charges by hospitals whether the consumer is insured or not for the same procedure.

25. Kenneth Plumer
-Wondered why methods of physicians collecting fees cannot be standardized. Why can't the doctor always handle the collecting of the bill. It would be a great help to people.

Dr. Bostwick responded that the third party payment system has created a system where doctors need to perform so much administrative work that they can't afford to accept assignment. Dr. Bostwick does not accept assignment. He said that he doesn't know how the consumer understands Medicare because it is very difficult for physicians to understand. He took issue with the reasonable charge maximums under Medicare also.

Dr. Bostwick also said that he feels no physician should accept assignment; that the patient should get paid directly for the service and the patient should pay the doctor.

Dr. Bostwick also said that Medicare does not let the doctor know what they are paying for in cases when the doctor does not accept assignment because they get no copy of the Explanation of Medical Benefits Form. So the doctor doesn't know what the patient is paying.

Gordon Browne responded that the doctors are free to do what they want. The consumer can use their market power to shop around and find the doctors who accept assignment.

Mr. Plumer said that doctors don't let you shop around because doctors won't take another doctor's patient. Gordon Browne said you have the right to shop around.

26. Pat Grant

-Should an insurance company be allowed to go up 50% in their premium at one time? Who controls this?

Tom Record said that such an increase is not necessarily against the law if it is a legitimate need. The Bureau looks at each rate filing as to whether it is excessive, inadequate or unfairly discriminatory. If the filing meets all standards, it is approved by the Bureau.

27. Evelyn Plumer

-Gave the example of her husband being in the hospital for 5 weeks and got a bill of over $22,000. The bill told her nothing, so she got an itemized bill and was amazed by the charges. For example, each tylenol cost $2; a total of $2000 was charged for IV solutions; a charge of $17.02 for a cream that cost $7 at the drug store. She wondered whether Medicare or Blue Cross/ Blue Shield get an itemized bill - whether they care how much hospitals are charging. "You are the people who are paying and you don't know about these costs. Why don't you check these things out?"

Jim Harrod said that it becomes extremely complicated. He said that Ted Hussey had said earlier that Blue Cross and Medicare don't pay their full share. Mr. Herrod said he took issue with that. BC pays on basis of cost plus 12%; and Medicare pays on the basis of cost as does Medicaid. What that means is that the actual cost of providing service to Medicaid, Medicare and BC patients is figured by how many services were provided to these types of patients multiplied by the actual cost of those services. We do this at an end of the year accounting. You are right we don't receive itemized bills. It doesn't speak to your issue of charges and how the hospitals come up with those charges. Each one of those costs includes some of the overhead of the hospital.

Stuart Fergusson said that in fact the itemized bill is fictitious because it is not what the hospital is getting paid by BC/BS or Medicare. It raises the whole cost shifting problem. The private pay patient is therefore being charged to help pay the bills for the Medicare patients.

Jim Harrod said this raises the whole issue of payor equity, which means that people should pay their fair share. Stuart

pointed out that as Medicare cuts back, the hospital will have to place more fictitious charges on to the private payors.

Gordon said that Mrs. Plumer very dramatically pointed out the problem that the Health Facilities Cost Review Board had been examining and had concluded that hospitals have to be put on a budget. That's the start. Secondly, the cost shifting issue is a real problem. As government and other third party payors say enough is enough, we are only going to pay what we believe is fair. As they define that and as hospitals look to preserve their revenues - we must assure that the private payor does not get over burdened. We can do this by 1) putting hospitals on a budget and 2) have all payors covered by the same system so that you can't shift costs to those best able to pay.

28. Consumer

-How can we all take more responsibility for our own health care costs? What can we do?

Gordon Browne said we must 1) take better care of ourselves 2) make sure that we don't get unnecessary care by refusing hospital care for things that we can get done more cheaply and 3) get support for cost control proposals.

Dr. Bostwick added that the patient and physician must discuss what the patient wants. Doctors assume that all people want the Cadillac treatment, but all don't. Also, the federal requirements cost so much to comply with, and some of them are just plain stupid.

Ted Hussey said that in response to Gordon Browne's comments, he doesn't care which way you reimburse physicians, it won't make any difference. Having the budgets set won't make the difference. The basic problem is that there are more older people than in years past and their care is very costly - we must recognize that as a problem and deal with it. He said he was happy that people can get care today in hospitals and that the hospital doesn't have to tell them that they are over budget therefore the care can't be provided. The Maine Hospital Association doesn't want that to happen.

29. Woman Consumer

-Patients must talk to doctors about their care.

30. Ames Alden

-Felt the answer was Natinal Health Insurance.

31. Fred Webber

-Doctors and hospitals must be educated. That's the only way the costs will be cut.

Dr. Bostwick said that people must be willing to accept less than perfection. In China, they only operate on people to get them back to work. Their priorities are different. Consumers must tell the system what they want.

32. Louise White

-Doctor charges for making out insurance forms.

-Does the physician know what hospital charges for services ordered?

Dr. Bostwick said "no".

33. Woman Consumer

-Suggested that physicians prescribe small prescriptions until they know whether that drug will work.

-Stressed that things must be made more easily understood because it is so hard to deal with this health system.

-Asked why BC/BS didn't check out the costs charged more, "they are being ripped-off."

RESPONSE TO PUBLIC HEARINGS - WRITTEN

SUGGESTIONS & COMMENTS

1) Government should look into fraud and abuse and overbilling by hospitals and doctors rather than cutting benefits to the tax paying elderly. Mrs. X just received an "overpadded" bill from Mercy Hospital and was charged for a copy of an itemized bill. Everything on the bill is labeled miscellaneous - Medications, Medications miscellaneous, etc. Mrs. X supports itemized bills.

2) Mrs. X suggests curbs must be made on Medical costs. Judging from the amount of paperwork involved in a simple Medicare/ Blue Cross claim and its rejection or partial payment, this would be a good place to start reform. There must be limitations of medical costs.

   There is a concern among elderly, that many doctors are not greatly concerned about older patients. She hears complaints of poor, inadequate or non-existant communications between doctors, other professionals and patients.

   One real cruelty to patients might be eliminated. Sometimes one is forced to wait days or weeks for biopsy reports. Once reports are completed they ought not lie around until unconcerned workers or inflexible office routines permit release to frightened patients.

3) In 1979, Mrs. X was in the hospital for two weeks for a hip operation. She received a bill for:

   O.T. $84.00
   P.T. $12.00

   She questioned the bill. The $84.00 O.T. charge was for four sessions of therapy, however, she had only one session. The $12.00 P.T. charge was for a physical therapist to inform Mrs. X that she could receive P.T. the next day.

   She was charged 40¢ for each Tylenol III which she gets delivered to her home for 20¢ a pill from the pharmacy.

   She believes that hospitals are ripping off Medicare and Medicaid. Hospitals give you every test in the book whether needed or not. There are charges for services never received.

4) Mrs. X wrote to indicate the same review should be done on dentist charges. When she requested an itemized bill because she was appalled at the amount of "professional services", she was informed that it was not customary to send an itemized bill. She never returned to this dentist because of the manner in which she was treated.

5) Mrs. X strongly urged the Maine Committee on Aging to sponsor a measure to compel hospitals to issue a bill to all Medicaid and Medicare patients. Overcharging could be reduced if people knew what their bills are and could protest unreasonable charges. This would prevent rip-offs.

6) Mr. B was first hospitalized in July 1980. The hospital billed his insurance company directly, but expected him to pay the remaining portion. He insisted on receiving an itemized bill if he was expected to pay. He discovered he was being charged something like $75.00 for treatments he had not received, and requested a credit for the amount. They refused to credit him and gave him the run around. He invited them to sue as he felt he would gain more from the publicity than the hospital. Instantly, they credited the account for the disputed amount.

His second hospitalization in January 1981, he was asked to pay from the statement and sent an itemized bill when it was requested. He found several duplications, brought it to their attention and received credit. About $65.00 was involved and he doubted it was done intentially but errors were made.

He suggests that hospitals prefer to bill insurance companies directly as the bills are not checked item by item. Then the patient is asked to pay their portion from the statement and they do not know what they were charged for.

Most patients cannot understand their hospital bills and this is most unfortunate.

7) Mrs. X has Medicare B, plus Aetna Supplemental. After she was hospitalized, Aetna required an itemized bill. The hospital said it would send the bill, but Aetna insisted the bill be sent by the insured.

Her bill said she was on an IV for four days. Actually, she was only on it for two days. She told Medicare but she does not know what they did.

The past November she was hospitalized for two days. Seven medications were listed on the bill. One medication she knew she didn't take because she is allergic to it, and she doubted the others. The surgeon didn't know and the anesthetist named three medications. Four medications were charged that she never took.

Ideas

1) Why go into the hospital at 10:30 one morning if you are not going to be operated on until the next day - extra meals cost money.

2) Tests are often repeated, and there are too many chest X-rays. She had several views taken and they never discovered she had five broken ribs until a month later.

8) Mrs. X did not know that Medicare covered all the doctor bills, so she paid the bill in full. So the doctor got paid twice; by her and by Medicare. She wonders how frequently this occurs.

9) Mr. Z was billed for a day in the hospital that he was not there. This bill also showed $325.00 for medications that he was not sure he received.

His wife was also recently hospitalized. She was in intensive care five days and acute care for 10 days. She received a bill from seven different doctors. They do not understand why so many had to bill her or why 7 billings were required.

10) Mrs. X felt that the insurance companies are getting cheated by the doctors and hospitals and that it is time for the people to speak up against high prices. She believes President Reagan is doing the best he can so it is not his fault directly when Medicare benefits are cut. People should not be so greedy and should help other people more.

11) Mrs. X believes all senior citizens are concerned about the escalating costs of health care. How can a patient be sure prescribed tests/operations are necessary. What are the "bare bones" costs.

12) Mr. Z made some specific suggestions:

1) Convince the public to use professional medical care only when necessary. Practice health maintenance and good home remedies when suitable.

2) Limit the cost of regulation. Entice capable public-spirited individuals to assist locally on a volunteer basis. Avoid a large salaried body of regulators.

3) Modify the legal responsibility relationships so that expensive tests are not used "just in case" to cover unwarranted malpractice claims.

4) Promote clinical service and health maintenance organizations. Educate the public on the advantage of these. Promote use of government borrowing power, on a self liquidating basis, to initiate health centers.

5) Urge use of generic drugs wherever suitable.

6) Promote and subsidize training of technicians (sub-professionals) in the medical and nursing fields. These could handle much of the health care load more cheaply and expeditiously than waiting for a physicians services.

7) Consider a voucher system of payment for medical expenses with a cash rebate for underspending in any year.